

LAW, ETHICS AND MEDICINE

The unhealthy physician

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Background: Physicians, if affected by transmissible or impairing diseases, could be hazardous for third persons.

Aim: To solve the apparent chasm between patient's and sick worker's rights, a consensus-building process leading to hospital-wide policies is the better alternative to individual decision making.

Conclusions: Policies have to balance the rights of the sick worker, the right of the other workers, patients and customers, and society's expectations.

Physicians report significantly lower morbidity rate than the average occupations.¹ For this reason, in the past, resources devoted to the surveillance of physicians' health were significantly lower than those reserved to industrial workers' health.

It could be observed, however, that even if the percentage of unhealthy physicians is less than that in the general population, the fact remains that each of these cases might represent a temporary or definitive loss of a highly trained person, a financial liability to self and/or employer and a risk to patient safety despite the fact that a central role of a profession is the preservation of public safety and welfare. Indeed, over the past 15 years or so, practitioner-to-patient transmission of infections, and patient injuries caused by the negligence of physicians impaired by chemical dependency or disabling diseases, have become a major focus of popular concern.

Prevention of work-related injury and disease has been traditionally based on identification, measurement and control of chemical, physical and biological risk factors. Management of risk related to hazardous workers requires new techniques and procedures, and specific policies.

A high-quality preventive policy should be supported by ethically consistent decisions. These decisions will have different costs and benefits, which should be systematically analysed within the framework of different stakeholders: worker, patient and society, including healthcare organisations (HCO). The sick worker's interests include furthering one's career, role in organisation, right to privacy and right to freedom from discrimination. The patient's interests include protection from harm, right to autonomy and right to informed choice. The society's interests include maintaining effective and affordable health services, as well as the benefits and burdens of any policies.

BLOODBORNE INFECTIONS

Percutaneous injuries occur regularly during surgery and other invasive procedures, placing personnel and, to a lesser extent, patients at risk of infection from bloodborne (BB) pathogens (hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV). Studies in US teaching hospitals during 1990 showed that injuries occurred during 6.9% of the surgical procedures. In 32% of injuries to surgeons, the sharp object that caused the injury subsequently contacted the patient's surgical wound.² There is evidence that recontact is frequent and at higher rates in certain surgical settings. The deriving principle is that such settings should be considered as high risk for patients. High-risk or

"exposure-prone" procedures (EPPs) are those procedures with a potential for direct contact between the skin (usually finger or thumb) of the healthcare worker (HCW) and sharp surgical instruments, needles or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites.³

After 1991, the widespread use of standard infection-control precautions undoubtedly led to a reduction in doctor-to-patient transmission risk. The most recent literature review⁴ shows that worldwide cases of HCW-to-patient transmission of BB pathogens after 1991 is exceedingly low: 3 of 3527 surgical patients were infected with HIV from three HIV-infected HCWs (0.09% risk rate), 91 of 3079 were infected with HBV (2.96% risk rate), 39 of 9678 were infected with HCV (0.36% risk rate).

It could be supposed that there might have been other clusters of BB infections, which were not detected for two reasons. First, in approximately 70% of cases, BB infection is not clinically evident, which reduces the probability of cluster identification through routine surveillance. Second, the long incubation period of the disease could make the identification of a common source difficult.⁴ Even taking this possibility into account, transmission risk of BB disease from a provider to a patient is very low.

In the early 1990s, a cluster of six cases of transmission of HIV infection from a dentist in Florida to his patients⁵ rose patients' alarm and general debate, resulting in direct effects on federal and state policy.

In 1991, the Centers for Disease Control and Prevention (CDC) published their first comprehensive guidelines relative to HIV/HBV-infected HCWs.⁶ Subsequently, most European countries made their guidelines; a consensus document has been published in 2003.⁷

Since 1991, US Congress mandated states to adopt the CDC guidelines or their equivalent.⁸ European states generally have no national law concerning the infected HCWs.

In brief, the CDC guidelines state that: (1) infected HCWs who adhere to standard precautions and who do not perform EPPs pose no risk for transmitting BB infections; (2) infected HCWs who perform EPPs pose a low risk for transmitting BB infections; and (3) mandatory testing is not recommended. In addition, European guidelines rely upon the concept of threshold of infectivity. It could be defined as the level of viral load below which transmission does not occur or it is unlikely, or the

Abbreviations: BB, bloodborne; CDC, Centers for Disease Control and Prevention; EPP, exposure-prone procedures; HBV, hepatitis B virus; HCO, healthcare organisation; HCV, hepatitis C virus; HCW, healthcare worker

level of viral load below which the HCW can continue to work (to perform EPP).

The determination of which procedures were EPPs relied upon guidance from medical and dental professions. Until now, this guidance could not be provided, and EPP is still a vague entity. It could also be observed that injuries, when they occur, seem to be random, and not procedure-specific events. In retrospective studies of HBV infection, about one-third of patients were infected during low-risk procedures.⁹

CDC guidelines state that infected HCWs should not perform EPPs unless they have sought counsel from an expert review panel and have been advised under what circumstances, if any, they could continue to perform these procedures. Even if the panels permit them to practice, HCWs must still inform patients on their serological status.

It could be objected that, in the absence of precise guidelines, judgment is vulnerable to the particular biases and experiences of the members of the panel,¹⁰ as well as to conflict of interest of colleagues sitting on such a committee.¹¹

To attain a clearer understanding of the ethics of this complex issue, and of the sociopolitical and legal consequences of issuing either restrictive or non-restrictive guidelines, let us consider the perspectives of each of the stakeholders: patients, physicians and health facilities.

Patients

Patients have the right to obtain all relevant information concerning their treatment, including iatrogenic risk factors. Obtaining fully informed consent is morally necessary in order to acknowledge and respect patient's autonomy. Truth disclosure is an integral part of this acknowledgement. It has been demonstrated that patients do wish to have information about a risk from an infected physician to which they have had been exposed, even though that risk was very low.¹² Accusations of paternalism could arise from decisions to restrict information to patients. Even if the risk of doctor-to-patient transmission is extremely low, withholding information interferes with people's ability to make informed choices, and is likely to give rise to more confusion and unwarranted anxieties than it can prevent.¹³

The patients' right to know directly intersects with the rights of the practitioner to medical privacy, and right to practice. Forced disclosure of serological status to patients could be socially embarrassing and extensive, because patients have no duty of confidentiality.

It has been observed that procedures designed to protect the public against a very low risk, breaching the confidentiality of the HCW, had the perverse effect of reducing the willingness of health professionals to self-declare their risk, because their own rights had not been adequately safeguarded.¹⁴

Given the fact that provider-to-patient transmission accounts for only a minimal part of the burden of illness attributable to these pathogens, it could be observed that even complete withdrawal of infected physicians from every contact with their patients will not significantly improve the health of the population.¹⁵ Moreover, mandatory practice restrictions could result in a disincentive to HCWs conducting EPPs to treat patients.¹⁶ Fears about exceedingly remote risks could not justify acts of discrimination in medicine or elsewhere. There is a deep conceptual chasm between the logic of informed consent and the logic of anti-discrimination.¹⁷

More generally, it is apparent that there is a wide discrepancy between the amount of resources necessary to clarify the origin of a possible case of atypical nurse-to-patient transmission,¹⁸ and the lack of adherence to standard infection control practices, even in the US, where 1–3% of HCWs reuse the same needle and/or syringe on multiple patients.¹⁹ Strategies to prevent transmission of BB pathogens in the healthcare settings, including training and

oversight of personnel, written policies and procedures, and periodic reviews of staff practices, would probably be more efficient than practice restriction in infection control.

Workers

Workers, including physicians, have the right to safety and health at work. This implies that they should not be harmed by inappropriate policies for BB infections. The current climate of uncertainty as to what happens to HCWs who are found to be positive for BB pathogens undoubtedly contributes to the fear, which HCWs who perform invasive procedures have.¹⁰ Even in developed countries, physicians may still have anxiety, humiliation and loneliness after a needlestick.²⁰ This highlights the need for widespread adoption of needlestick-prevention devices in healthcare settings, together with post-exposure prophylaxis, counselling and other effective preventive measures. Injury prevention in an ergonomic workplace environment could substantially reduce the risk of doctor-to-patient transmission of BB pathogens, and could achieve high levels of patient safety without discrimination and invasion of privacy. Healthcare facilities undoubtedly have the duty to promote environmental safety.

On their own side, according to their duty of non-maleficence, physicians should know their own status for BB infections. Sometimes things go differently. A large percentage of physicians do not have a regular source of care, a characteristic that has been significantly associated with failure to use preventive services.²¹ When faced with contradictory managing procedures for infected workers, physicians, because of the fear of discrimination, do not seek diagnosis and treatment, because they have greater legal protection if they can honestly say that they did not know their serological status.²² Physicians are not legally obliged to undergo screening for BB infections. Although US hospitals occasionally require HCWs to be tested against their will, and courts have approved policies of this kind,⁸ in most European countries, workers are protected from employer's intrusive behaviour to prevent discrimination at work. It is apparent that full collaboration of physician is imperative. Physicians have a responsibility to maintain their health and wellness. Every physician should have a personal physician, and he or she has to seek appropriate help as necessary.²³

Traditional ethics, oriented towards the individual physician-patient relationship, failed to find an uncontroversial solution to these complex issues. Recent research has focused on trying to resolve the ethical dilemma at the organisational level.

Community

The HCO has the responsibility of implementing international guidelines and/or national policy at the local level. The HCO must take a public stand on controversial ethical issues, such as the one concerning the risk of transmission of BB pathogens, through a consensus building that leads to hospital-wide policies. Having a local, written policy is preferable to individual decisionmaking, because it is better suited to preserve the autonomy of the parties involved.²⁴ The task of policy writing must be as concerned with the process of reaching consensus by open deliberation as with the actual outcome of the process. Different strategies to deal with HCWs infected with BB pathogens have been proposed.²⁵ The final objective could be the zero-risk (excluding all infected workers from surgical procedures) or a minimal-risk strategy, based on periodical testing of viral load in infected workers.²⁶ Each of these different solutions can be equally reasonable, depending on how much weight the deliberative process gives to any of the substantive principles that reflect the obligation of a HCO: to care for the sick, to treat employees with respect, to act in a

public spirit and to use resources reasonably.²⁴ The adopted policy should be feasible, viable and cost-effective.

In three hospitals, where I have been in charge of the medical surveillance of HCWs, this consensus procedure led to the following policy: (1) workers are screened for BB infections (screening for HIV is non-mandatory); (2) counselling and treatment are offered to infective workers; (3) workers infected with HBV with HBV DNA levels $>10^4$ genome equivalent/ml are excluded from first-aid and emergency surgical procedures, but are allowed to perform elective surgical procedures, including EPPs, in patients immunised for HBV; (4) surgeons positive for HIV are excluded from EPPs; and (5) surgeons infected with HCV are excluded from first-aid and emergency procedures and allowed to perform surgical practices, including EPPs, using safety devices (double gloves, safe surgical devices). The definition of which procedure is exposure-prone is taken in accordance with the worker himself. Patients are informed of the statistical risks of infection due to BB pathogens, and also of risks related to haemorrhage, wound infection and anaesthesia. In doing so, the privacy of the infected worker is protected, and the interests of the patients are maintained. To improve the post-injury surveillance of workers, patients are requested to consent to blood testing for BB pathogens if a surgeon or other member of the operating team is injured during the operation, as part of their informed-consent procedure. Patients exposed to an infected HCWs blood receive post-exposure prophylaxis. Obviously, this policy is not the best in absolute, and it is not a guideline for other HCO, but it has been judged suitable in the specific sociopolitical and organisational situation of the above hospitals.

Unfortunately, some HCO still follow the “null” approach, leaving the burden of decision about preventive measures to the unhealthy physician himself or herself. I recently witnessed the case of a university teacher, who had been working as a surgeon since 1969 in a university hospital. In 1972, he developed HBV infection that subsequently healed. In 1974, he developed “non-A-non-B hepatitis”, later diagnosed as chronic HCV-infection. In 1975, he was diagnosed at King’s College Hospital, London as having hypersensitivity (toxic) hepatitis from halogenated anaesthetics. The combined adverse effect of the toxic factor and HCV infection was alarming. The surgeon signalled his health status to the university hospital management, but no appropriate preventive measure was taken. The surgeon tried to bypass the gas hazard, by using neuroleptoanalgesia; anaesthetic gas, however, were used by neighbouring surgeons. In subsequent years, when exposed to anaesthetic gas, he showed recurrent increases of alanine transaminase. In 1998, he completely ceased surgical activity and sued the hospital. The court rejected his claim on the basis that the observed enzymatic changes could not be attributed, without doubt, to the anaesthetic gas hazard, owing to the confounding effect of HCV chronic liver infection. No penal charge of university management was decided, notwithstanding the proved absence of preventive measures, both at individual and collective level. Given the fact that the surgeon remained HCV-RNA positive for 25 years of his career, the risk of having transmitted HCV in at least one of the procedures performed, can be evaluated to be almost 88%.²⁷

It is imperative that HCO effectively screen and manage infectious HCWs. Use of preventive (standard) strategies, and of newly developed safety devices, should substantially reduce the already extremely low risks for provider-to-patient transmission of BB pathogens.

The impaired physician

The American Medical Association defines an impaired physician as a physician who is “unable to practice medicine

with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the ageing process or loss of motor skill, or excessive use or misuse of drugs including alcohol”.²⁸ A physician is considered to be impaired when personal problems (eg, chemical dependence, emotional disorders and physical disability) or professional difficulties (eg, malpractice litigation stress and incompetence) begin to interfere with the ability to function in the profession and in personal life.

It has been estimated that 8–15% of practicing physicians will be impaired at some point of their career.^{29–30}

The impaired physician could cause harm to patients at least to the same degree as representing a transmission risk of BB pathogens.

As with the transmissible infections, at least three parties have direct interests in this issue: the physician’s interests in keeping his or her career and in performing his or her role to improve the health of patients; the patient’s interest in having the best level of care; and the society’s interest in maintaining an effective and affordable healthcare system.

It is apparent that clinical ethics, while focusing only on individual doctor and his or her patients on a case-by-case basis, failed to recognise the effects of the organisational culture in which healthcare is delivered. Most of the questions arising from conflicting interests at the individual level could be posed and (tentatively) resolved at the collective level.

Patients

From the patient’s point of view, physician’s impairment could be seen as one of the leading factors of medical malpractice. Physicians impaired by alcohol or drug are negligent and should be submitted to disciplinary process. In the US, every state has a medical licensure board responsible for controlling entry into the medical profession by means of licensure and disciplining physicians who are incompetent or engage in unprofessional conduct. Although the broad definition of “impairment” would lead one to suspect that large number of impaired professionals might be affected by the medical boards, the numbers do not demonstrate that outcome: state medical boards actually stripped the licences of only 0.25% of all licensed physicians in the US.³¹ Furthermore, because each state licensing board has broad discretion in the scope of disciplinary decisions, actions due to impairment could be ignored in one state, trigger only periodic monitoring in a second and be grounds for sanctions in a third.³¹ The broad range of disciplinary options available to medical boards sometimes led to decisions, such as restricting the practice of physicians with records of criminal or sexual misconduct to inmates of correctional facilities or mental hospitals, which seem unethical both for the incarcerated and for the society as a whole.^{32–33}

Workers

There is little doubt that physicians who are impaired for any reason must refrain from assuming responsibilities of patient care that they cannot discharge safely and effectively. It is in the physicians’ own interests in avoiding harm to their patients. The majority of physicians are at least partially attracted to their profession by the desire to help people by improving their health, well-being and quality of life. They would feel at least some degree of remorse if they had harmed one of their patients. Surely, they would also try to avoid the legal difficulties that would ensue. Impaired physicians should disclose their health status to licensing and health facility authorities.³⁴

The question, however, arises, whether the physician’s impairing condition lowers his or her level of self-conscience,

as it happens in most cases of neuropsychological or addictive disorders.

Clinical ethics is currently trying to solve this problem at the individual level, giving each physician the task to supervise his or her colleagues' health.

The American Medical Association's code of medical ethics states that physicians have an ethical obligation to report impaired, incompetent and unethical colleagues in accordance with the legal requirements in each state.²⁸ In June 2004, the Council on Ethical and Judicial Affairs updated an opinion,³⁵ clearly stating that physicians who receive reports of inappropriate behaviour have an ethical duty to critically, objectively and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority, even if reports are submitted anonymously.

A growing body of court decisions have considered even the treating physician's duty to breach confidentiality and to report previously undisclosed impairment of a fellow physician who is under treatment.³⁶

The large majority of physicians say they would report a doctor who was impaired by alcohol or drugs, or had a physical or mental illness that could affect his or her job performance or judgement.³⁷ These responses, however, could represent conviction more than action. Reporting doctors to the authorities is not an easy choice. Clearly, many physicians would rather not do something that could end a colleague's career or boomerang on them. Physicians are more likely to report against the colleague physician if the person has caused a problem with one of their patients. Sanctions against impaired physicians would be ethically permissible if they were necessary to avert a serious risk to patients, or if the limitations of human rights are trivial.

The problem is that it is often hard to spot impaired physicians before they harm patients. This seems to be a hard task for the physician alone.

Community

The society's response to the problem has been the creation of public and private facilities for impaired physicians.

Virtually all states in the US have programmes for "impaired physicians", and most of them are reaching out to impaired professionals through medical societies.^{23 38 39} Similar experiments have been conducted more recently in UK,⁴⁰ Canada,^{41 42} Australia⁴³ and Spain.⁴⁴ Programmes developed under the auspices of the state licensing board, are generally known as "diversion programmes", as the doctors are diverted to treatment rather than to disciplinary action.

On their own side, most US hospitals put a reporting system in place to ensure that impaired physicians are treated before quality of care is reduced.³⁸ Reporting procedures protect the confidentiality of reporting physicians and focus on rehabilitating, protecting and reinstating physicians successfully.

It is mandatory to define in advance, in each HCO, the rules for reporting. These rules must walk a fine line, upholding a standard of patient care while preserving the rights of reporters and reportees alike. Presumably, physicians performing far below the standard level of care will be reported within their institution or to their governing body a sufficient number of times that corrective actions be taken, but what about the majority of physicians who perform slightly below optimal performance? Do patients have a right to know any type of private decision about physicians which could affect their consent decision, including factors influencing performance such as stress, fatigue, side effects of drugs, family problems or legal disputes? Or could they have access to other private information such as the physician's performance on professional practice, history of malpractice suits or substance

misuse? The potential harm to patients must be weighed against the invasion of the physician's privacy and the resulting consequences to his or her practice.¹⁰ The doctrine of informed consent should not require impaired physicians to disclose their status to patients. Informed consent requires disclosure of material risks, not remote risks. If the risks were significant, the logical remedy would be to restrict the physician's right to practice, not to notify the patient.⁸ Modern courts in the US hold that impaired physicians have no legal duty to disclose their status to their patients.³⁴

A special aspect of the same picture is privacy for physicians who seek help for neuropsychological diseases or addictive disorders. While undergoing therapy, the impaired physician should be entitled to full confidentiality as in any other patient-physician relationship.⁴⁵

Each HCO must develop a balanced, science-based analysis of these issues and propose preventive measures in a written policy document.

At the collective level, the problem of fairness or distributive justice, which involves distributing the benefits and burdens of a policy or decision equally among the different groups involved, should be resolved.¹⁰ It will be unfair if impaired or infected physicians bear all the burdens of what is a public health problem. An unhealthy physicians' situation could be remedied through compensatory measures—that is, retraining and/or financial compensation—without putting patients at risk.

Unfortunately, even in the US, not every health facility has services for unhealthy physicians. In most cases, the failure of some hospitals to form physician aid committees or occupational health services is due to the fact that the medical staff leadership does not recognise the problem.⁴⁶

Moreover, the solution to the problem of the impaired physician needs a transcultural effort. In the English-speaking countries, the concept of the "impaired physician" is covered in medicine training, and it is a regular topic in journals, and scientific and professional meetings. In European countries, programmes for treatment and rehabilitation of impaired HCWs are still lacking, and knowledge on the issue is scarce, even on the part of specialists in occupational and preventive medicine.

CONCLUSION

The management of the unhealthy doctor implies an original methodological approach, involving full cooperation of employer, employees and health and safety consultants in a process of consensus building that leads to hospital-wide policies. The controversial issues of safeguarding both patient's and diseased worker's health could lead to different and equally reasonable solutions, depending on how much weight the deliberative process gives to any of the substantive principles that are proper to the HCO's role. Policies concerning informed consent, non-compliance, confidentiality, responsibility of workers, disclosure of risk to customers, non-discrimination and counselling of workers, should be clarified. Costs and targets of the policy need to be stated, and also the means of recovering costs to ensure viability.

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